VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 21, 2017

Rachael Parker, Manager
Sterling House At Richmond
61 Farr Road
Richmond, VT 05477-9301

Dear Ms. Parker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on February 22, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 0591 | A. BUILDING: _____ B. WING _____ | C 02/22/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| STERLING HOUSE AT RICHMOND | 61 FARR ROAD RICHMOND, VT 05477 |

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| R100 | Initial Comments:<br><br>An on site complaint investigation was conducted by the Division of Licensing and Protection on 2/22/17. The findings include the following:<br><br>R128 V. RESIDENT CARE AND HOME SERVICES<br>SS=D<br><br>5.5 General Care<br><br>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to administer Insulin by injection consistent with physician orders for 1 of 3 residents, (Resident #5). The findings include the following:<br><br>Per review of the physician's electronic prescription order dated 1/9/17, for Resident #1, directs staff to administer Lantus Solostar Insulin 30 Units subcutaneous (SC) daily at 8 AM.<br><br>Per medication pass audit at 8:30 AM, the Medication Technician was observed administrating, Lantus Solostar Insulin 38 Units SC to Resident #5.<br><br>Per interview with the facility manager confirmation was made that the physician sent the electronic order to the pharmacy identifying the decrease in the dosage of Lantus Insulin to 30 Units SC daily. The facility did not receive the order change until the Medication Administration Record (MAR) was delivered to the facility. The | R100<br><br>R128 | R128 5.5 General care<br><br>1. Resident #5 MD notified. No negative effects. MD orders in place and match MAR. Audited other residents on insulin and orders matches as well. The bowel medication was consumed only by that resident.<br>2. Medpassers will be re-educated by RN for med pass procedure.<br>3. This process will be monitored by the RN with random Monthly observation of medpassers providing medications for three months.<br>4. 3/21/2017 | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard Parker — TITLE: manager — (X6) DATE: 3/13/17



R128 - R171 POC's accepted 3/17/17 MBertrand RN/PMC

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| R128 | Continued From page 1<br>MAR for the month of February identified the dosage change. The Registered Nurse who reconciled the monthly MAR turnover, did not identify the dosage change.<br><br>Per interview with Medication Technician in the presence of the Manager, s/he confirms that 38 units of Lantus Insulin was administered, on the following days: February 1,3,6,7,8,9,14,15,17,and 22, 2017. | R128 | | |
| R136 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.7. Assessment<br><br>5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to reassess annually, 1 of 6 sampled residents.<br>For Resident #2, the findings include the following:<br><br>Per medical record review, Resident #2 was admitted on 2/12/14. The annual State mandated assessment was completed on 12/18/15.<br><br>Per interview with the manager, confirmation was made that the resident has not been reassessed since the 2015 assessment. | R136 | R136 5.7 Assessment<br><br>1. Resident Assessment was completed for Resident #1 and Resident #2 2/24/2017<br>2. Reviewed with Licensed Staff that RN's must assess each resident annually and with a change in resident's physical or mental condition.<br>3. This process will be monitored by the manager through monthly audits<br>4. 03/24/2017 | |

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| R145 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.9.c (2)<br><br>Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to revise a written care plan for 2 of 6 sampled residents describing the care and services necessary to assist the resident to maintain independence and well being. For Residents #1 and #2, the findings include the following:<br><br>1. Per record review for Resident #1's, care plan was developed and signed by the Registered Nurse dated 9/3/15, identifies that the resident is receiving Visiting Nurse Association (VNA) Physical Therapy visits 2 x's a week, and on 9/6 the resident has open skin areas on his/her toes, is to have feet elevated and apply dry dressing. The plan identifies that the resident is able to manage his/her suprapubic catheter bag, but needs cueing.<br><br>Per interview with the facility manager, Resident #1's skin areas have healed, the resident is no longer receiving physical therapy and the suprapubic catheter changes are being managed by the VNA. Facility staff are managing emptying and cleaning of the suprapubic | R145 | R145 Resident Care and Home services 5.9.c(2)<br><br>1. Care Plans for Resident #1 and #2 were updated.<br>2. Nursing staff educated about updating care plans with changes.<br>3. Random monthly audits to ensure care plans are reflective of resident's current needs.<br>4. 2/24/2017 | |

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| R145 | Continued From page 3<br>drainage bags.<br><br>2. Per record review for Resident #2, care plan developed and signed by the Registered Nurse dated 12/18/15 and 1/20/17, identifies that the resident ambulates independently. No assistive devices and he/she has a history of rare falls. The resident has a Foley bag to free drainage that s/he manages independently.<br><br>Per review of nurses notes, documentation identifies that the resident has had 3 falls in the month of January 2017 all of which required hospital evaluation. The manager confirms that the resident currently uses a rolling walker for ambulation and Bayada Visiting Nurse is currently managing the catheter changes. | R145 | R161 5.10 b Medication Management<br><br>1. Resident MD notified. No negative effects. MD orders in place and match MAR. The bowel medication was consumed by Resident #3 only.<br>2. Medpassers will be reeducated by RN for med pass procedures. Administration of medications that require training will be reviewed by manager prior to administration to ensure the proper education has been provided by the RN and documented.<br>3. This process will be monitored by the RN with random Monthly observation of medpassers providing medications for three months.<br>4. 3/21/2017 | |
| R161 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review the facility manager failed to ensure that medications are handled according to the home's policies and that designated staff are fully trained in those policies and procedures, for 2 of 2 residents (Resident #5 and #6), during a medication pass. The findings include the following: | R161 | | |

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| R161 | Continued From page 4<br><br>1. Per observation during the medication audit at 8:30 AM, the Medication Technician was observed administrating, Lantus Solostar Insulin 38 Units subcutaneous (SC) to Resident #5, even after the resident alerted the technician that the Insulin order was changed to 30 units of Lantus daily. The Medication Technician voiced to the resident that she did not know of the change and proceeded to administer the 38 units.<br><br>Per review of the physician's electronic prescription order dated 1/9/17, for Resident #1, directs staff to administer Lantus Solostar Insulin 30 Units SC daily at 8 AM. The Medication Administration Record dated (MAR) 2/1/17, directs staff to administer Lantus Solostar Insulin 30 Units SC daily at 8 AM.<br><br>Per interview with the facility manager confirmation was made that the physician sent the electronic order to the pharmacy identifying the decrease in the dosage of Lantus Insulin to 30 Units SC daily. The facility did not receive the order change until the MAR was delivered to the facility. The Registered Nurse who reconciled the monthly MAR turnover, did not identify the dosage change.<br><br>Per interview with Medication Tech in the presence of the Manager, s/he confirms that 38 units of Lantus Insulin was administered, on the following days: February 1,3,6,7,8,9,14,15,17,and 22, 2017. The Medication Technician voiced that she did not know of the change and proceeded to administer the 38 units. S/He also confirmed that the Medication Administration Record was not clearly reviewed prior to the administration of the medication.<br><br>2. Per observation during the medication pass | R161 | | |

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| R161 | Continued From page 5 | R161 | | |

audit at 8:30 AM, the Medication Technician was observed preparing Citracel powder 1 Tablespoon that was placed in 6 ounces of water, for Resident #6. S/He proceeded to leave the prepared bowel medication at the dining room table in the location Resident #6 normally sits at. S/He left the room and returned to the nurses station to continue with her/his morning routine. The medication technician later confirmed that s/he did leave the medication unattended in the dining room.

Per review of the Medication Administration Test dated 11/7/14 completed by this particular Medication Technician, question #11 identifies the correct response (False) to the question "When administering medications, it's OK to leave a resident's medications at the bedside or on the dining room table as long as the resident is present".

3. Per observation during the medication pass audit at 8:30 AM, the Medication Technician prepared morning bowel medications for residents to ingest with their breakfast. S/He then continued by preparing oral and injectable medications for Resident #3 and then delivered those medications. The medication technician applied disposable gloves prior to conducting a blood glucose test on resident #5 and then proceeded to administer injectable insulin. The medication technician never changed his/her gloves nor did s/he wash/sanitize his/her hands as s/he proceeded from one task to another.

Per review of the Medication Safety policy/preventing infection identifies that hand hygiene is to be completed either by washing with soap and water or utilizing an alcohol base sanitizer as the staff member goes from one

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| R161 | Continued From page 6<br>resident to another. | R161 | | |
| R165 SS=E | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:<br>i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;<br>ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;<br>iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the Registered Nurse (RN) failed to ensure the proper administration of medications for unlicensed staff by teaching, monitoring and evaluating designated staff performance in carrying out the nurse's instruction for 2 of 2 Medication pass audits observed (Resident #5 and #6). The findings include the following: | R165 | R165 5.10.d Medication Management<br><br>1. Resident MD notified. No negative effects. MD orders in place and match MAR. The bowel medication was consumed by Resident #3 only.<br>2. Reviewed with Licensed Staff that RN's must delegate the responsibility to designated staff for medication administration.<br>3. This process will be monitored by the manager. Administration of medications that require training will be reviewed by manager prior to administration to ensure the proper education has been provided by the RN and documented.<br>4. 03/28/2017 | |

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| R165 | Continued From page 7 | R165 | | |

1. Per observation during the medication audit at 8:30 AM, the Medication Technician was observed administrating, Lantus Solostar Insulin 38 Units subcutaneous (SC) to Resident #5, even after the resident alerted the technician that the Insulin order was changed to 30 units of Lantus daily. The Medication Technician voiced to the resident that she did not know of the change and proceeded to administer the 38 units.

Per review of the physician's electronic prescription order dated 1/9/17, for Resident #1, directs staff to administer Lantus Solostar Insulin 30 Units SC daily at 8 AM. The Medication Administration Record dated (MAR) 2/1/17, directs staff to administer Lantus Solostar Insulin 30 Units SC daily at 8 AM.

Per interview with the facility manager confirmation was made that the physician sent the electronic order to the pharmacy identifying the decrease in the dosage of Lantus Insulin to 30 Units SC daily. The facility did not receive the order change until the MAR was delivered to the facility. The Registered Nurse who reconciled the monthly MAR turnover, did not identify the dosage change.

Per interview with Medication Tech in the presence of the Manager, s/he confirms that 38 units of Lantus Insulin was administered, on the following days: February 1,3,6,7,8,9,14,15,17,and 22, 2017. The Medication Technician voiced that she did not know of the change and proceeded to administer the 38 units. S/He also confirmed that the Medication Administration Record was not clearly reviewed prior to the administration of the medication.

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| R165 | Continued From page 8 | R165 | | |

2. Per observation during the medication pass audit at 8:30 AM, the Medication Technician was observed preparing Citracel powder 1 Tablespoon placed in approximately 6 ounces of water, for Resident #6. S/He proceeded to leave the prepared bowel medication at the dining room table in the location Resident #6 normally sits at. S/He left the room and returned to the nurses station to continue with her morning routine. The medication technician later confirmed that she did leave the medication unattended in the dining room.

Per review of the Medication Administration Test dated 11/7/14 completed by this particular Medication Technician, question #11 identifies the correct response (False) to the question "When administering medications, it's OK to leave a resident's medications at the bedside or on the dining room table as long as the resident is present".

3. Per observation during the medication pass audit at 8:30 AM, the Medication Technician prepared morning bowel medications for residents to ingest with their breakfast. S/He then continued by preparing oral and injectable medications for Resident #3 and then delivered those medications. The medication technician applied disposable gloves prior to conducting a blood glucose test on resident #5 and then proceeded to administer injectable insulin. The medication technician never changed his/her gloves nor did s/he wash/sanitize his/her hands as she proceeded from one task to another.

Per review of the Medication Safety policy/preventing infection identifies that hand hygiene is to be completed either by washing with soap and water or utilizing an alcohol base

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| R165 | Continued From page 9<br>sanitizer as the staff member goes from one resident to another. | R165 | | |
| R168 SS=D | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management<br><br>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:<br><br>(6) Insulin. Staff other than a nurse may administer insulin injections only when:<br><br>i. The diabetic resident's condition and medication regimen is considered stable by the registered nurse who is responsible for delegating the administration; and<br><br>ii. The designated staff to administer insulin to the resident have received additional training in the administration of insulin, including return demonstration, and the registered nurse has deemed them competent and documented that assessment; and<br><br>iii. The registered nurse monitors the resident's condition regularly and is available when changes in condition or medication might occur.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review the Registered Nurse (RN), failed to ensure that staff are educated and monitored for the administration of injectable insulin for 1 of 3 observed administrations (Resident #5). The findings include the following: | R168 | R 168 5.10.d.6<br>Medication Management<br>Insulin<br><br>1. Resident #5 MD notified. No negative effects. MD orders in place and match MAR.<br>2. RN reviewed additional education required to provide insulin and documentation requirements. Medpassers re-educated on insulin injections.<br>3. This process will be monitored by the manager. Administration of medications that require training will be reviewed by manager prior to administration to ensure the proper education has been provided by the RN and documented.<br>4. 3/28/2017 | |

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| R168 | Continued From page 10<br><br>Per observation during the medication audit at 8:30 AM, the Medication Technician was observed administrating, Lantus Solostar Insulin 38 Units subcutaneous (SC) to Resident #5, even after the resident alerted the technician that the Insulin order was changed to 30 units of Lantus daily. The Medication Technician voiced to the resident that she did not know of the change and proceeded to administer the 38 units.<br><br>Per interview with Medication Tech in the presence of the Manager, s/he confirms that 38 units of Lantus Insulin was administered, on the following days: February 1,3,6,7,8,9,14,15,17,and 22, 2017. S/He also confirmed that the Medication Administration Record was not clearly reviewed prior to the administration of the medication.<br><br>Per telephone interview with the manager on 2/24/17 at 9 AM, the medication technician was hired on 10/28/14 as a resident care attendant and on 11/7/14 completed a medication technician course at the facility and completed the medication administration test, resulting in a pass rate of above 90%. The manager confirms that there is no evidence that the employee received additional training in the administration of insulin, including a return demonstration. Nor is there evidence that the employee was deemed competent to administer injectable insulin by the RN. | R168 | | |
| R171 SS=F | V. RESIDENT CARE AND HOME SERVICES<br><br>5.10 Medication Management | R171 | | |

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| R171 | Continued From page 11<br>5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include:<br><br>(1) Documentation that medications were administered as ordered;<br>(2) All instances of refusal of medications, including the reason why and the actions taken by the home;<br>(3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect;<br>(4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and<br>(5) For residents receiving psychoactive medications, a record of monitoring for side effects.<br>(6) All incidents of medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to document that medications were administered as ordered by the physician for 14 of 19 Medication Administration Records (MAR's) reviewed. The facility also failed to document the insulin injection site for 3 of 3 residents who receive daily insulin injections (Residents #5, #7 and #8). The findings include the following:<br><br>1. Per MAR review for 14 residents, dated 2/1 through 2/21/17, disclosed approximately 71 uninitiated times when medications were not documented as administered. There is no | R171 | R171 5.10.g Medication Management<br><br>1. MARS reviewed for employee re-education.<br>2. Medpassers re-educated for documentation requirements.<br>3. Manager will randomly audit weekly x 4weeks MARS for ommissions.<br>4. 3/28/2017 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0591 | A. BUILDING: _____ B. WING _____ | C 02/22/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE AT RICHMOND | 61 FARR ROAD RICHMOND, VT 05477 |

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|---|---|---|---|---|
| R171 | Continued From page 12<br><br>documentation to identify the reason medications were not administered. The medications varied from prescription to over the counter medications. These medication were ordered to treat the following conditions, but not limited to: cardiac problems, diabetes, depression, gastric reflux and constipation.<br><br>Per review of the facilities policies titled "Medication Management-Documentation of Medications" identifies that documentation will include the following: 1) All medications administered by staff, including the site of any injectable administered; 2) All instances of refusal of medication, including the reason why and the actions taken by the facility. Procedure identifies "if medications are refused or withheld, the med passer returns to the MAR and circles his/her initials on the medication administration record and writes an explanatory note on the reverse side of the MAR, noting the date and time along with the explanation.<br><br>Per interview with the facility manager, confirmation was made that the MAR's have not been initialed by the Medication Technician evidencing that medications were administered and/or completed as ordered by the physician. Nor is there documentation identifying the reason why medications were not provided as directed.<br><br>3. Per review of Medication Administration Records (MAR's) for the month of February 2017, for Residents #5, #7 and #8, identifies that they receive injectable insulin daily. There is no documentation identifying the site the insulin was injected into at each administration.<br><br>Per facility policy "Medication | R171 | | |

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|---|---|---|---|---|
| R171 | Continued From page 13<br>Management/Administration of Insulin" identifies that documentation includes the site rotation. | R171 | | |